STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175353	A. BUILDING _____ B. WING _____	C 05/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARMA HEALTH AND REHAB	605 EAST MELVIN ST PO BOX 789 ARMA, KS 66712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following deficiency citation represents the findings of complaint investigation #86867.	F 000		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This Requirement is not met as evidenced by: The facility reported a census of 27 residents and identified none considered as elopement risks. The sample included 3 residents reviewed for elopement/accidents. Based on observation, record review and interview, the facility failed to ensure 1 of the 3 sampled residents (#01) did not leave the facility, without staff knowledge, who fell approximately 1 1/2 blocks from the facility and received bruising and abrasions. Findings included: - Review of the closed medical record of resident #01, revealed on 11/27/13 the facility admitted resident #01. The resident was sent to the nursing facility following a court appearance. The physician's admission orders also documented diagnoses which included senile dementia with depression features. The annual MDS (minimum data set) assessment, dated 12/12/14, documented the resident with moderately impaired cognition, with a BIMS (brief interview for mental status) score of	F 323		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 323	Continued From page 1 8. The assessment identified delusions but no behaviors or wandering noted, balance was unsteady but able to stabilize self, no range of motion limits, use of a wheelchair, required supervision of ADLs (activities of daily living), no falls since the prior assessment, and did become short of breath upon exertion or lying flat. The 3/14/15 quarterly MDS identified the resident with cognition intact with the BIMS score of 13. All other areas remained without change from the 12/12/14 MDS. The care plan, dated 12/4/14, included the resident's impaired decision making r/t (related to) senile dementia. Instructions to the staff included, fall prevention program, non skid material to the wheelchair seat, and to add skid strips to the floor at the bedside. The care plan did identify the resident went to the convenient store and notified staff of his/her leaving and returning. Nurses notes dated 5/4/15 documented after 9:00 P.M., the resident packed his/her belongings, placed them in his/her wheelchair and left through the facility front door without notifying staff. The resident walked pushing his/her wheelchair, east 1 and 1/2 blocks from the facility, on the small city paved street where he/she fell. On 5/11/15 at 9:00 AM, ancillary staff C reported the evening of the resident's elopement, shortly after 9:00 P.M., he/she drove east of the facility and noted the resident on the pavement with the wheelchair a distance away. The staff member called the administrator to report the incident. A neighbor had already called the police department. Police and staff from the nursing home arrived and placed the resident into the	F 323		

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F 323	Continued From page 2	F 323		

wheelchair and pushed him/her back to the nursing home. The resident informed the nursing staff at the time, that he/she was going to leave again sometime.

Further nurses notes from the incident on 5/4/15 documented following the resident's return to the facility, the resident refused to allow the licensed nurse to perform any assessment. The resident denied having any pain and was placed on 15 minute visual checks. The resident threatened to the staff he/she would leave the facility again. Just after midnight, the resident allowed the nurse to complete vital signs and neurological checks which were noted as within normal limits.

Nurses notes dated 5/5/15 at 3:00 P.M., revealed the facility transferred the resident to another nursing facility with a special locked unit for safety.

Review of the new facility special care unit's admission assessment, dated 5/5/15, included the resident sustained a right knee abrasion 1 by 1.5 cm (centimeter), and a left elbow bruise 7 by 4.5 cm. The assessment identified the resident as alert and his/her memory was documented as okay. The facility had not completed a new MDS with BIMS to identify the resident actual cognition ability yet when reviewed on 5/11/15.

On 5/11/15 at 9:45 A.M., administrator A acknowledged the incident was not reported to the state agency because the resident went outside the facility frequently to smoke and to the neighbors to visit. The administrator also acknowledged the resident knew the code to the front door and opened it without assistance. However, the facility lacked a sign in or out system in place for his/her going out and coming

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F 323	Continued From page 3 back as their revised 9/2012, policy stated. On 5/11/15 at 2:30 P.M., social service staff E reported the resident walked over a block to the ball field to watch kids playing ball at times and would always come back. On 5/11/15 at 3:40 P.M., certified nursing staff F and G reported the resident would wave at them or tell them when he/she went out of the facility, which was frequently. On 5/11/15 at 4:15 P.M., two other residents (#04 and #05) acknowledged the resident talked about leaving the facility all the time to go home as he/she had to go to work. The facility failed to complete safety assessments to determine the resident safe enough to go out of the facility by him/herself; failed to implement a sign in and out procedure to monitor the resident's location; failed to provide adequate supervision and the resident left the facility after dark without staff knowledge, walked 1 and 1/2 blocks, fell on the paved street and required assistance to get up and return to the facility.	F 323		